DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 Governors Drive
Pierre, South Dakota 57501-2291
(605) 773-3495
Fax: (605) 773-5246
medical@state.sd.us

DATE: _____

GENERAL PRIOR AUTHORIZATION REQUEST FORM

Please Check box:

Hospital
☐ Long Term Care Hospital
☐ NICU
☐ Psychiatric
☐ Rehabilitation
☐ Specialty

Physician
☐ Medical Surgical

Psychological
☐ Inpatient Psychiatric Facility
☐ Residential

Home Care Services
☐ Private Duty Nursing
☐ Durable Medical Equipment
☐ Extended Home Health Aide
☐ Medication
☐ Nutrition

☐ **EPSDT**

☐ **Other**

First date of service _____ Last date of service _____

GENERAL INFORMATION			
Recipient. Number–9 digits	Last Name	First Name	Date of Birth Sex:
Diagnosis Code	Procedure Code	Procedure Description	Quantity

EXPLANATION OF NECESSITY FOR PROCEDURES (Attach supporting x-rays, lab reports, operative reports, and discharge summaries etc. if indicated)

PROVIDER INFORMATION

Medical Assistance Provider Number _____

I certify that the information given in this form is a true and accurate medical indication for the procedures required. All other treatment to correct this problem has been exhausted.

_____ _____
Provider Signature Date

Provider Name:_____

Address:_____

_____

Provider Phone #_____ Fax #_____ E-Mail _____